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Introducing Medical Office Practice in Ethiopia is Critical for Enhancing Access to Health and Job Creation

Position Paper

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Background

The then Food, Medicine and Healthcare and Control Authority (FMHACA) introduced various health facility standards driven by the demand for quality health services in Ethiopia. These standards for the private health sec-tor cover a diverse range of clinical services including medium clinics, higher clinics, medical centers, specialty centers and hospitals. However, according to recent studies, the facility standards are perceived as unattainable, the infrastructure and personnel requirements are extreme. It requires huge investment to purchase equipment and establish or rent premises that fulfills the requirements. All in all, the health care service standards are unanimously described as overly ambitious that have totally disregarded the context it is to be implemented. The very

existence of the regulations has done more damage by discouraging many to provide needful services to the community than ensuring safety and quality of services. Even amongst the few who managed to operate under these regulations, the sentiment is that it isn't implemented consistently across the board (urban/rural, public/private), further weakening the argument in favor or its continuing implementation.

Regulatory bodies disproportionately emphasized the measurement of the physical environment. The exis-ting regulations do not observe or audit the standard of care. While there may be some importance in having a well-designed space for health care delivery, the priori-tization misses the importance of diversifying care with quality. Its focus is on a step wise improvement in physi-cal space, that is partly driven by market forces. Becau-se of the regulators skewed focus on the environment, there is an associated high price tag to starting and/or expanding private health care business.

Most health care workers do not have the means and the opportunity to start such services. And those who were able to do so had to practice for a number of years before they were able to afford to open their own or in partnership with others. The service gap therefore is filled by business personnel with neither health care background nor passion to improve quality and expand, access and affordability. This subsequently forces the private health system to focus on profit to stay afloat or become the primary intention. This vicious cycle will harden the regulators to impose more sanctions and regulation to control the few private facilities that are thriving.

Hence, these stringent facility standards have been barriers for many not to enter into the private health sector, thus, the sector remained under-developed. This in turn results in access for health care to dwindle and quality of care to deteriorate. Besides, this has contributed for many health professionals to neither be

self-employed nor work for potential investors in the sector, making a significant number of healthcare workers unemployed for the first time in the nation's history.

This recent paradox of unemployed health professionals and increase in the public's demand for quality and access for better health service begs for new models of service delivery to address both gaps. Hence, it is time to think of a new health service delivery model that responds to the public need for quality including improvement in waiting time, better doctor patient interaction, focus on health promotion and maintenance. Medical office practice could address these demands. This innovative way of health care service delivery enhances access to quality health care services while allowing junior health professionals to have new opportunities.

Medical Office Practice

Medical office practice can be run either in solo or group manner depending on multiple factors. While solo and group medical practices are viable options to expand small health care businesses as well as expand services, there are some differences between the two approaches in different contexts. Personal accessibility to a single known point where various medical needs can be attended to in a coordinated and convenient manner is more readily provided in group than solo practices. Productivity "hours devoted to patient care" and "office visits" may also vary,

A group practice can scrutinize the qualifications of a physician seeking group affiliation and provide an environment conducive to enhancing competence. Standards requirements for solo practices are minimal compared to group practices, but both have limited standard burden compared to multi specialized and big hospitals. This would allow for flexibility on service delivery models.

Depending on the way group practice is structured care continuity is maintained, however, solo practice may be interrupted depending on the solo practitioner's availability and competing priorities including travel and study. In group setting this can be addressed using alternate providers.

The cost of care for clients in both solo and group practices are smaller than traditional service delivery models, especially if they are geographically distributed in high population density areas. Effective outpatient care is available in group practice in place of more costly inpatient hospital services. When incentives for use of preventive medical care are present, the need for more serious and costly care later may be reduced.

Doctor-patient relationship and ultimate improved communication is seen in practices that are small and closer to where people live. These practices were non-existent or were only short lived to date in Ethiopia because people neither saw the potential nor the value accrued over a long period. Those with the idea neither had the platform to take their agenda forward nor the power to pursue for development of standard for the practice.

The role of Ministry of Health (MoH) in creating the enabling environment is critical for medical office practice to take off and sustain. This includes making entry into health care business less resource intensive or investment with minimal startup cost. The MoH should be acknowledged for recognizing the need to have these new models of health care delivery introduced for multiple reasons which include 1) it absorbs significant number of unemployed health workforce including doctors 2) it is an opportunity to promote provision of quality and patient-centered service, and 3) it will inspire changes in the larger public and private healthcare delivery system through healthy competition.

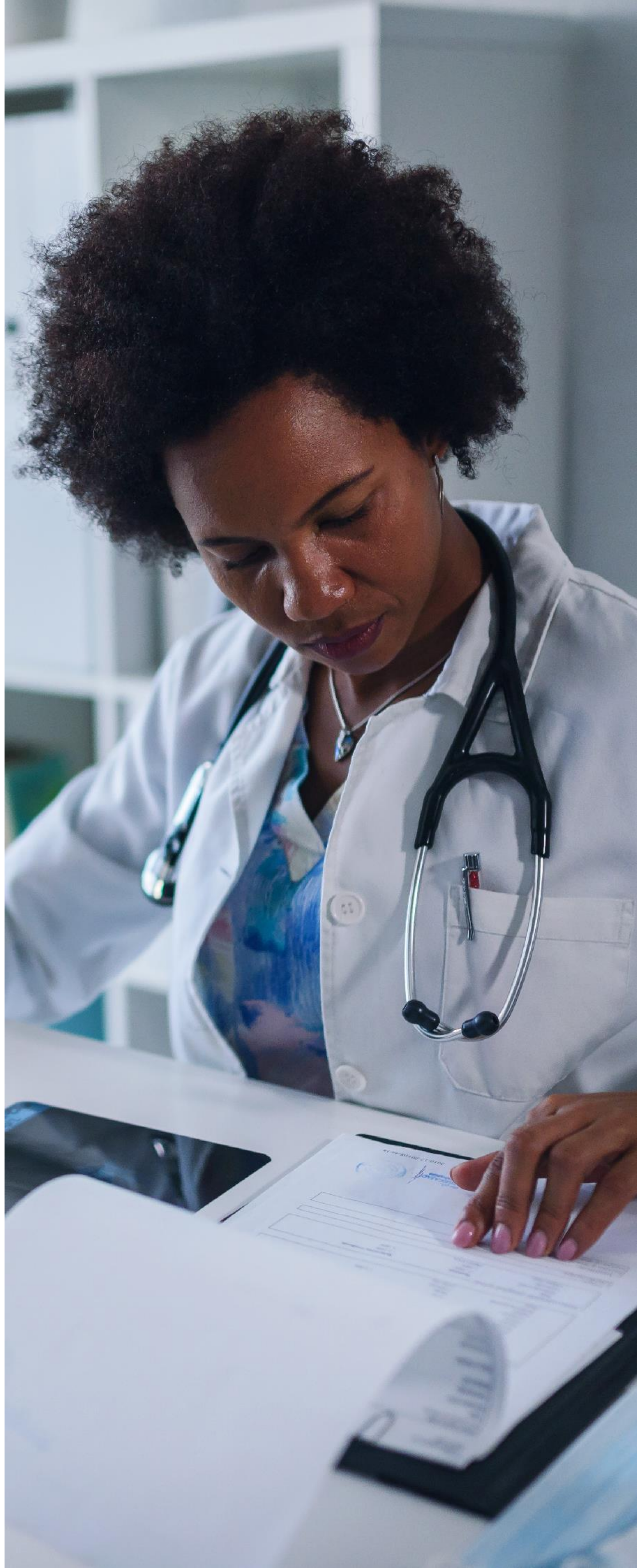
Hence, recently it has taken the lead and drafted the policy framework in consultation with key stakeholders including the private health sector. In its draft document, it indicated recognizing the involvement of the private health sector which if a favorable policy environment exists would flourish to uptake a significant number of graduates. The MoH has already endorsed solo and group office medical practices to be part of the health care delivery model and will soon communicate to the responsible authorities on its decision.

Actions, Solutions and Challenges

Action 1: Ethiopia needs new health care delivery models like solo and group medical office practice

The dominant business model in health care is "solution shop" which focuses on treatment ignoring health promotion and maintenance. Preventive, promotive, and primary care services are highly needed by the public and can be taken closer to the community and minimize the time and emotional burden from visiting oversubscribed public hospitals and the cost burden from expensive private hospitals. Hence, medical office practice could play a significant role in health maintenance and promotion. It only requires reasonable investment and improves access and quality for health care and reduces unemployment.

The opportunities that exist to make a new model work are: growth in group living constructions either through condominiums, apartments or real estate developments that often bring a large number of people to one location creating a huge customer base; expansion in use of technology to bridge communication between healthcare providers and the public; public sector's willingness to work with private sector on a win-win strategy that adds value; development partners' and corporations' interest in a short-cycle self-sufficiency experiments that can be sustained by local



businesses or government and a new generation of health care workers who are young, unemployed and willing to try new approaches for health delivery and earn a living.

Besides, there are plenty of prospects that can be harnessed while introducing office for medical practice. Ethiopia is not the first country to introduce the practice. It has been part of the health care delivery model in most developed and developing countries. Hence, so much can be learned from the experience of other countries.

In addition, there is huge interest from the government side as the MoH has already flagged health workers unemployment as its priority agenda. Therefore, the government is keen to support in creating the enabling environment including removing the policy barriers.

There is also an advance in utilization of technology in health care. The health sector interest in digitizing health can be taken as an important opportunity. The flourishing of electronic medical record and continuous interest of most private facilities in introducing EMR is one sign that more of the digital technology could be utilized in medical office practice. These include booking, making investigation requests and reports, and patient communication, in patient education, and etc.

Certain challenges can be anticipated during the early implementation of medical office practice. These include lack of experience and finance for professionals to start up business, the incapability of the public to pay for the services, and lack of data on number and type of health professionals who would be interested in the private practice. Moreover, people in the private sector with established business and some senior professionals on the field may not welcome the idea.

For public to use such services, while insurance is an obvious financing avenue that the government should promote, a partnership between public and private sectors should be looked at critically. New graduates might not have the acceptable competency to deliver appropriate care in office practice as there is limited support from seniors or they are by their own. Inferior care which results in grave consequence on patient safety and the likelihood of malpractice may impact the public view on the practice model. Earning the public trust is not going to be easy.

Development of guidelines and protocol, training, and mentorship are critical for successful implementation of the model. Besides, as the health professionals training lack entrepreneurial skills, some of them may find running business challenging and may get discouraged if their business is not thriving. Again, providing them with business skills should be considered if the new practice continues to grow.

People in the private sector with established business and some senior professionals on the field may not also welcome the idea. Reports from certain countries indicated that government licensing and regulation of clinicians requires patients to pay higher prices than necessary to receive care from clinicians who have more training by forcing specialization in places where the need for majority is on primary health care.

Members of the regulated professions may enact barriers to lower-cost competitors which can be further elaborated to say a specialist with strong voice in policy shaping may prevent service expansion by non-specialists, as seen by the resistance towards task sharing and task shifting despite the data. While not a robust strategy, activist health care workers lobby seek to reduce the range of services that other categories of clinicians can perform, because such limits reduce competition for their professions.

Action 2: The standard should focus on clinical outcome and have reasonable requirements

Assuring quality clinical care is much more important and should count as a better indicator than size and number of rooms for the premise. Hence, the standard should include more detail on how to assure patient care and quality of service. In starting medical office practice, the standards in terms of definition, premise, personal, the product (equipment) and the services to be rendered should look like the following.

Premise: Two rooms of reasonable size (one for examination and one for reception seems right for solo practice and in group practice each should have one examination room while sharing the reception.) No medical waste is expected and there is no storage of equipment.

Professional: A doctor or a health officer with a nurse as a receptionist may suffice to run a solo practice whereas the group practice involves more doctors yet sharing reception and other facilities.

Practice: Consultation, home care service, teleconsultation, and telemedicine to be part of the office practice. The scope of service can be summarized into three as 1) to use the office only for consultation, treatment. and referral 2) on top of what is indicated in point number 1, some diagnostics but not procedures 3) not only diagnostics but also some office procedures to be performed.

Products: Some basic equipment include statoscope, BP apparatus, Pulse oximeter, Glucometer, Emergency kit, Free call lines and Application/s for home care.

Action 3: The medical office practice should be well regulated

There should be strong regulatory mechanisms for office practice to assure patient safety. The decision by policy makers is a direct reflection of social trust, perception of the labor market, and culture. Increased call for tight regulation is common when medical malpractice is reported frequently, so having a system to review irregularities in following set rules, instituting prevention tools for life threatening errors and education of ethics in an ongoing manner is needed for stepwise relaxation of regulations.

For such new practice, regular review and improving regular requirements is necessary as long as it is a consultative process. The regulation should observe or audit the standard of care. The quality of office practice can be assured through making proper documentation as one important requirement. There should be standard formats to be filled out. Technology should be introduced to the practice. DH should be integrated to enhance the new practices. DH policy should indicate the strategies for betterment of office for medical practice.

All in all, various quality improvement and quality assurance mechanisms should be in place. Currently the practice is regulated by the health regulation directorate at the MoH. However, the regulatory work shouldn't be left only for government entities, third party and independent actors such as professional associations, consumers associations, quality and standard groups, patient's groups all need to have a seat on the decision-making table on standards. When the time is right, professional associations should take over once they develop the capacity.

Action 4: The administration and governance of the medical office practice re- quires multi sectoral engagement and the private health sector should be consulted in developing the standards

Standards for solo and group practice should be done in consultation with the private health sectors to ensure there is a balance between assuring quality and investment. Even though the private sector has huge potential and interest to take it forward, as this health care delivery model is new in the country, implementation requires multi sector involvement whereby the government plays the huge part. There has to be partnership among the sectors to work closely and rectify challenges all the way. For developing the standard, Ethiopian standard agency, MoH, Health professional associations, public and private health facility, regional/city health service providers and universities as potential contributors and relevant stakeholders, each having specific roles and responsibilities.

The government could play a huge role in removing the barriers or the policy impediments making it easy for the private sector to invest, health professionals to enter private practice with affordable investment, create an enabling environment for unemployed health worker teams and start group practice. MoH is expected to develop the policy framework which facilitates entry many practitioners into private practice or become entrepreneurs. It has to create the channel to communicate and reach all stakeholders and obtain

their active engagement for the new practice model to expand and attract more individuals. MoH is also expected to take the lead in developing the standards.

However, the MoH spearheading the process does not mean it should organize the registration, securing them practice, premises, and finance. The professional associations are better positioned in supporting those responsibilities indicated earlier. Professional association could take the role of regulating the professionals and the practice for ethical practice. The private health sector associations could assure quality of care and find means to engage more individuals to be part of the private practice.

Action 5: Various financial mechanisms should be put in place for sustaining medical office practice

Financing a startup business for new graduates may be difficult. The government needs to bring this to drivers of financing in this country. For example, a bank in Ethiopia will never consider health care a viable business, and it would rather give loan for startup or expansion of other sectors than making such services available for health care businesses. The new health care delivery models can be financed by private banks and creditors. The government can also arrange loans from microfinance enterprises.

To attract more people there should be an incentive package. Improving domestic access to health care business financing is a winning plan for all in the relationship - financially, economically and developmentally. Government needs to provide policy direction for health care business financing for solo practitioners, group practitioners, corporate health care services etc. Even then, the models should be studied for financial viability.

Different modalities could be available to finance the business. Availing loans from microenterprises, the MoH being a guarantor and having development partners to put aside some seed money through linking with banks can be thought of. The money from the development partners can also be pooled centrally as a revolving fund so that new batch of loan applicants have the opportunity. A good number of private investors will be interested to enter such business, hence, will hire those who are keen to start private practice.

Action 6: The government should encourage the private sector to innovate health care delivery models

The private health sector should continuously innovate delivery of health care to increase access and services quality and create more jobs. Generally, the health care delivery business is described as 'traditional'. There are multiple innovations in health care delivery in Ethiopia, the only problem with the innovations is that they are all "prescribed" by the government. The private sector is expected to execute what is recommended in a top-down fashion and never encouraged to innovate.

For example, one can't open a network of facilities under one management, because the regulation expects that every clinic in the network needs to have all management necessary otherwise it can't operate. Operating a pre-hospital care is encouraged, but private facilities cannot be licensed for that, there are no regulations for home -based care services in the country that is a leader in community health work through health extensions workers.

The immediate answer for any new approach or potentially innovative solutions is "No". Often only a few in the government provide opportunity to listen and show a path to take an innovative solution to the next level of adapting and developing standards if there are none. One has to wait until the government tries it or when an outside group recommends before a new approach is open for testing.

The whole focus of health care service innovation and expansion needs to be revisited. First, health care services should have patients in the center. What and how they access services should be looked at from their perspective, and regulatory approaches should then address those needs that arise from that focus.

Conclusion

Existing private health service modalities are limited and require huge investment. This has been a barrier for the private health sector to expand existing services or enter into new markets. This in turn has resulted in low access and quality for health care service provision and left a huge number of healthcare providers including physicians unemployed.

Therefore, it is necessary to introduce new health care delivery models, and medical office practice could be one. Standard should focus on clinical outcomes and the development process should involve the private health sector. The requirements to set up the practice should require minimal investment so that it attracts many professionals. The practice, premise, personnel, and product should be decided in consultation with all relevant stakeholders. The practice should be well regulated to assure patient safety and viability of the practice through introducing quality improvement and assurance mechanisms. The practice should be governed well through engaging multiple stakeholders and financing the business requires thinking out of the box and bold decisions.

Note:

This document is an extraction and summary of key findings from a formal study conducted by Precise Consult International. Both primary and secondary data were used. While the former were collected via key informant interviews and focus group discussions, the latter were collected from different organizations as well as from internet resources. In addition, the study employed descriptive data analysis techniques and benchmarking of best-practice lessons for Ethiopia.

All data that were used in this brief are referred in detail in the full research document which can be found by visiting www.preciseethiopia.com or by email request to info@preciseethiopia.com.

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